



## Medical/Health History

Please fill out this medical and personal history very carefully. When you come for your next visit we will go over the history together and discuss any questions that you might have. Just leave blank any questions you cannot answer.

### PERSONAL INFORMATION

Your Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Occupation \_\_\_\_\_ Email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Usual Weight \_\_\_\_\_  
Marital Status \_\_\_\_\_ Ethnicity \_\_\_\_\_ SSI# \_\_\_\_\_  
Last grade of High School completed \_\_\_\_\_ Years of post-secondary formal education \_\_\_\_\_  
Partner's Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Ethnicity \_\_\_\_\_ SSI# \_\_\_\_\_  
Last grade of High School completed \_\_\_\_\_ Years of post-secondary formal education \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_  
Insurance \_\_\_\_\_ Family Doctor/Pediatrician \_\_\_\_\_

### MENSTRUAL HISTORY

When do you think you may have conceived? \_\_\_\_\_  
How long is your menstrual cycle? \_\_\_\_\_ Last Menstrual Period (LMP) \_\_\_\_\_  
Was it normal in length and heaviness of flow? \_\_\_\_\_  
Did you have a pregnancy test? \_\_\_\_\_ Was this a planned pregnancy? \_\_\_\_\_  
Previous Menstrual Period (PMP) \_\_\_\_\_  
How old were you when you began menstruating? \_\_\_\_\_  
Were you using birth control when you conceived? \_\_\_\_\_  
If yes, what type? \_\_\_\_\_

### OBSTETRICAL HISTORY

Total Pregnancies \_\_\_\_\_ Full Term \_\_\_\_\_ Premature \_\_\_\_\_  
Abortion \_\_\_\_\_ Ectopic \_\_\_\_\_ Miscarriage \_\_\_\_\_  
Living Children \_\_\_\_\_ Twins \_\_\_\_\_ Cesarean \_\_\_\_\_ VBAC \_\_\_\_\_



**Please list information about your previous births: (starting with your first birth)**

Date: Mo/Yr \_\_\_\_\_ # of weeks at delivery \_\_\_\_\_ Length of labor \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Sex: M/F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Complications: \_\_\_\_\_

Date: Mo/Yr \_\_\_\_\_ # of weeks at delivery \_\_\_\_\_ Length of labor \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Sex: M/F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Complications: \_\_\_\_\_

Date: Mo/Yr \_\_\_\_\_ # of weeks at delivery \_\_\_\_\_ Length of labor \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Sex: M/F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Complications: \_\_\_\_\_

Date: Mo/Yr \_\_\_\_\_ # of weeks at delivery \_\_\_\_\_ Length of labor \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Sex: M/F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Complications: \_\_\_\_\_

Date: Mo/Yr \_\_\_\_\_ # of weeks at delivery \_\_\_\_\_ Length of labor \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Sex: M/F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Complications: \_\_\_\_\_

**Describe anything else you would like us to know about your previous births.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you nurse any of your babies? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

If no, why didn't you nurse and/or what problems did you experience with nursing? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



## MEDICAL HISTORY

Please check if you have had any of the following conditions. In the space below record date, treatment, and any follow-up you received. Also feel free to list any other important conditions and/or concerns.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Liver problems         | <input type="checkbox"/> Heart disease       |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Bowel problems      |
| <input type="checkbox"/> Hemorrhage              | <input type="checkbox"/> Severe headaches       | <input type="checkbox"/> Eye/vision problems |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Thyroid problems       | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Pelvic/back injuries    | <input type="checkbox"/> Skin problems          | <input type="checkbox"/> Allergies           |
| <input type="checkbox"/> Ear/hearing problems    | <input type="checkbox"/> Phlebitis/varicosities | <input type="checkbox"/> Stomach problems    |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Surgeries              | <input type="checkbox"/> Dental problems     |
| <input type="checkbox"/> Bladder infection       | <input type="checkbox"/> Urinary Tract Surgery  | <input type="checkbox"/> Asthma              |

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Are there any hereditary diseases or conditions in your family such as diabetes, cancer, heart disease, hypertension, phenylketonuria, neural tube defects, or chromosomal disorders? (List and indicate which relative.)

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YES  NO Do you have any drug sensitivities or allergies?

If yes, list \_\_\_\_\_

YES  NO Have you or the father of your baby ever had a baby with a birth defect or mental retardation?

YES  NO Do you or the father of your baby have any family members with birth defects or conditions diagnosed as genetic or inherited?

YES  NO Are you or the father of your baby from any of these ethnic/racial groups?

(please check)  Ashkenazi Jew  Black/African  Asian  Aleutian  Mediterranean

How many times was your mother pregnant? \_\_\_\_\_

How many children did she have? \_\_\_\_\_ Did she have any miscarriages? \_\_\_\_\_

Were there any complications with her pregnancies? \_\_\_\_\_

How long were her labors? \_\_\_\_\_ How much did you weigh at birth? \_\_\_\_\_



- YES  NO Have you had or now have mental health problems?
- YES  NO Have you ever used drugs/alcohol excessively?
- YES  NO Have you ever experienced dramatic fluctuations in your weight?
- YES  NO Have you ever had anorexia, bulimia, or eating problems?
- YES  NO Have you ever been in an abusive relationship, including now, or been abused in the past (physically and emotionally intimidated, beaten, or injured)?
- YES  NO Have you ever been raped?
- YES  NO Have you ever had a blood transfusion?

Do you have any special dietary considerations, such as vegetarianism, lactose intolerance, or phenylketonuria? \_\_\_\_\_

What do you generally do for exercise? \_\_\_\_\_

When was the date of your last dental visit? \_\_\_\_\_

Do you have any untreated dental problems? \_\_\_\_\_

### **GYNECOLOGICAL/CONTRACEPTIVE HISTORY**

When was your last Pap smear? \_\_\_\_\_

Have you ever had an abnormal Pap?  YES  NO If so, when? \_\_\_\_\_

Do you do self breast exams?  YES  NO

Please check if you have ever had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Yeast  | <input type="checkbox"/> Breast surgery   | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Bacterial vaginosis                          | <input type="checkbox"/> Trichomonas      | <input type="checkbox"/> Gardnerella       |
| <input type="checkbox"/> Condyloma (genital warts)                    | <input type="checkbox"/> Chlamydia        | <input type="checkbox"/> Gonorrhea         |
| <input type="checkbox"/> Genital Herpes                               | <input type="checkbox"/> PID              | <input type="checkbox"/> Genital sores     |
| <input type="checkbox"/> Human Papilloma Virus (HPV)                  | <input type="checkbox"/> Syphilis         | <input type="checkbox"/> Oral herpes       |
| <input type="checkbox"/> Cervicitis                                   | <input type="checkbox"/> Cervical surgery | <input type="checkbox"/> Cervical polyp    |
| <input type="checkbox"/> Ovarian cyst                                 | <input type="checkbox"/> Fibroids         | <input type="checkbox"/> Endometriosis     |
| <input type="checkbox"/> Breast lumps                                 | <input type="checkbox"/> Uterine surgery  | <input type="checkbox"/> Infertility       |
| <input type="checkbox"/> Other reproductive problems/conditions _____ |   |  |

Have you ever used any method of birth control  YES  NO If so, what kind? \_\_\_\_\_

Problems/complications?

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## CURRENT PREGNANCY

What prenatal care have you had up to the present? Please list doctors, clinics, and hospitals where you have had care, what was done, and especially if you have had any lab work or special testing done.

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Please check if you have had any of the following problems during this pregnancy:

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|--|--|--|
| <input type="checkbox"/> Nausea            | <input type="checkbox"/> Vomiting                  | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Indigestion           |
| <input type="checkbox"/> Leg cramps        | <input type="checkbox"/> Rash                      | <input type="checkbox"/> Backache              |
| <input type="checkbox"/> Swelling          | <input type="checkbox"/> Constipation              | <input type="checkbox"/> Diarrhea              |
| <input type="checkbox"/> Urinary problems  | <input type="checkbox"/> Abdominal/pelvic pain     | <input type="checkbox"/> Loneliness            |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Bleeding gums             | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Hemorrhoids       | <input type="checkbox"/> Vaginal bleeding/spotting | <input type="checkbox"/> Depression            |
| <input type="checkbox"/> Family problems   | <input type="checkbox"/> Varicose veins            | <input type="checkbox"/> Work problems         |

Have you used or been exposed to any of the following during this pregnancy?

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Tobacco                              | <input type="checkbox"/> Viruses      | <input type="checkbox"/> Caffeine                    |
| <input type="checkbox"/> Alcohol                              | <input type="checkbox"/> Cats         | <input type="checkbox"/> Non-prescription drugs      |
| <input type="checkbox"/> Marijuana                            | <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Prescription drugs          |
| <input type="checkbox"/> Cocaine                              | <input type="checkbox"/> Ultrasound   | <input type="checkbox"/> Fumes/sprays                |
| <input type="checkbox"/> Street drugs                         | <input type="checkbox"/> X-Rays       | <input type="checkbox"/> Other environmental hazards |
| <input type="checkbox"/> Measles or other infectious diseases |                                       |  |

What herbs, vitamins and/or supplements are you currently taking?

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Do you regularly visit a chiropractor? If so, how frequently? \_\_\_\_\_

Do you regularly visit a homeopath or naturopath? If so, how frequently? \_\_\_\_\_

Do you plan to breast feed this baby? If so, how long would you like to nurse? \_\_\_\_\_

Are there any particular ethnic, cultural, or religious preferences for your care that you would like to discuss? \_\_\_\_\_

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Do you feel you have adequate resources, i.e. food, shelter, money, for this pregnancy? \_\_\_\_\_

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Please list the people you plan to invite to your birth \_\_\_\_\_

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Have you faced any opposition to your plans for home birth? \_\_\_\_\_

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**Please give some thought to the following questions and write your ideas. If you and your partner are together, each of you should answer. Read all questions before answering.**

Why do you want to have this baby at home \_\_\_\_\_

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Partner: \_\_\_\_\_

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What do you see as the duties or responsibilities of your midwives? \_\_\_\_\_

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Partner: \_\_\_\_\_

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*Mountain View Midwives*

In choosing home birth and licensed midwifery care, you are going against current cultural birth norms. Only about 1% of all births in the United States each year occur at home. Many people consider home birth irresponsible and some have even likened it to child abuse. For example, if the birth results in damage or death in the hospital, no one will come to you and say, "See what happens when you have your baby in the hospital." However if a problem arises at home, you will invariably be asked this question regarding home birth again and again. What risks do you think there are with home birth?

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Partner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you feel about going to hospital to deliver if your midwives feel that complications are arising? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Partner \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you think you might deal with the problem of a baby or mother who suffered permanent injury or died at home? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Partner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

